Check Stop Payment Form

I. Account/Transaction Information

Name: ______________________________________ **Account Number:** ___________________

Day time Phone Number: _______________________ **Date of Request:** ____________________

Payee: ____ **Check Number:** ______________________

Date of Check: ______________________ **Amount of Check:** ____________________

Reason: ____

II.Disclosure & Indemnification

This stop payment will stay in effect for 6 months. To re invoke another 6 months, you must contact the Credit union prior to the expiration date. Your signature confirms the information provided to stop payment on this item is correct and that you acknowledge the terms. allU.S. Credit Union cannot stop payment on an item that has already cleared or on items presented within 24 hours of placing the stop payment.

I am an authorized signer, or otherwise have authority to act on the account identified in this statement.

I have read the statement in its entirety and attest that the information provided is true and correct.

Member Signature: _______________________________ Date: ______________________________

Mail to: allUS Credit Union
1410 N Main St.Salinas, CA 93906

For Office Use Only

Received By ___ Branch _____________ Date ____________

Processed By ___Branch ______________ Date ____________